NATIONAL LEGAL INNOVATION STRATEGY Ireland

INNOVATING EUROPEAN LAWYERS TO ADVANCE THE RIGHTS OF CHILDREN WITH DISABILITIES

Belgium

Bulgaria

Czech Republic and Slovakia

Ireland

Lithuania

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Introduction

Ireland ratified the UN Convention on the Rights of the Child (CRC) in 1992 without reservation,[1] the Optional Protocol on the Involvement of Children in Armed Conflict in 2002[2] and the Optional Protocol on a Communications Procedure in 2014.[3] Ireland signed the UN Convention on the Rights of Persons with Disabilities (CRPD) on 30 March 2007 but has it has yet to be ratified. This means that the CRPD is not binding on the Irish State. Children with disabilities continue to face many barriers in Ireland.

The majority of students with special educational needs in Ireland attend mainstream schools with additional supports.[4] However, there are many barriers for children with disabilities in fully accessing their right to inclusive education. There is a continuing delay in the entry into force of all provisions of the Education of Persons with Special Educational Needs (EPSEN) Act 2004 to provide for the inclusive education of children with special needs.[5] While the EPSEN Act was passed by the Oireachtas more than 12 years ago, key provisions of the legislation are not yet in force including provisions that would confer on children a statutory entitlement to an educational assessment, an individual educational plan and delivery of services based on the individual plan.[6]

Some schools erect overt and/or 'soft' barriers to prevent or discourage parents from enrolling their children such as advising parents that a different school is more 'suitable' for their child or has more resources for supporting students with special educational needs.[7] Children with special educational needs are overrepresented in schools designated under the "Delivering Equality of Opportunity in Schools" (DEIS) programme.[8] Children and young people also have difficulties in accessing reasonable accommodations when undertaking state examinations.[9]

In Ireland, the provision of support for "low-incidence" special educational needs is based on a diagnostic or medical approach.[10] This has resulted in some children being diagnosed for the

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[1] Office of the High Commissioner for Human Rights, 'Ratification Status for CRC' https://treaties.un.org/PagesViewDetails.aspx?src=TREATY&mtdsg_no=IV- 11&chapter=4&lang=en#EndDec accessed 31 March 2017.

[2] Office of the High Commissioner for Human Rights, 'Ratification Status for CRC-OP-AC - Optional Protocol to the Convention on the Rights of the Child' http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?Treaty=CRC&Lang=en accessed 31 March 2017.

[3] Ibid.

[4] Department of Education and Skills, *Review of the Pilot of a New Model for Allocating Teaching Resources to Mainstream Schools to Support Pupils with Special Educational Needs* (DES 2016) 1.

[5] Education for Persons with Special Educational Needs Act 2004, s 2. This section provides that 'a child with special educational needs shall be educated in an inclusive environment with children who do not have such needs unless the nature or degree of those needs of the child is such that to do so would be inconsistent with— (a) the best interests of the child as determined in accordance with any assessment carried out under this Act, or (b) the effective provision of education for children with whom the child is to be educated'.

[6] Minister for Education and Skills, Richard Bruton TD, Dáil Debates, Special Educational Needs Services Provision, 19 October 2016 [31092/16].

[7] National Council for Special Education, *Supporting Children with Special Educational Needs in Schools.* NCSE Policy Advice Paper No. 4, (NCSE 2013) 4.

[8] E. Smyth et al, *Learning from the Evaluation of DEIS*, (Economic and Social Research Institute 2015).

[9] Ombudsman for Children, Reasonable Accommodations for Certificate Examinations (RACE): Complaints to the Ombudsman for Children June 2016 https://www.oco.ie/wp-content/uploads/2016/06/Reasonable-Accomodations-for-Certificate-Examinations.pdf accessed 22 February 2017.

[10] Department of Education and Skills, *Review of the Pilot of a New Model for Allocating Teaching Resources to Mainstream Schools to Support Pupils with Special Educational Needs* (DES 2016) 2.

purposes of resource allocation and being labelled with a disability just to receive extra teaching support while children whose parents cannot afford to pay for a private diagnosis experience delays in accessing supports.[11] The expected introduction of a new resource allocation model piloted by the Department of Education and Skills[12] across mainstream primary and post primary schools from September 2017 is a welcome development.[13]

Disability supports and services are undergoing reform, moving towards a new model of supporting children to **live in the community** by providing supports centred on the needs of individuals.[14] In 2011, the Government proposed a new model of accommodation which involved moving adults and children with disabilities from congregated settings to accommodation in the community and related supports.[15] In line with the policy, work is ongoing to implement a new model of residential support where people with disabilities are supported to live together in houses that are dispersed throughout the local community.[16] The Health Information and Quality Authority (HIQA) is responsible for the registration and inspection of residential services for children and adults with disabilities. All designated centres for people with disabilities are required to register with HIQA and are inspected against the National Standards for Residential Services for Children and Adults with Disabilities.[17]

The Health Service Executive (HSE) is implementing a model of service provision called Progressing Disability Services for Children and Young People (0–18s) which aims to create 'one clear pathway to services for all children with disabilities according to need'.[18] However more work is necessary to provide coordinated and consistent services throughout the country.[19] Community care services include access to public health nurses, social workers, occupational therapists, home help services, chiropody services, speech and language therapy services, respite care and day care.[20] There is a need for the HSE to develop a national policy and establish a new model for providing homecare packages to support children with enhanced care needs to remain in the home environment.[21]

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[11] Ibid. 3-4.

[12] Minister for Education and Skills, Richard Bruton TD, Dáil Debates, Special Educational Needs Data, 29 November 2016.

[13] Department of Education and Skills, 'Better outcomes for children with special educational needs is the key goal of new model – Minister Bruton' (18 January 2017) < http://www.education.ie/en/Press-Events/Press-Releases/2017-Press-Releases/PR2017-01-18.html> accessed 6 February 2017.

[14] Inclusion Ireland, 'Pre-Budget Submission 2016' < http://www.inclusionireland.ie/sites/default/files/attach/basic-page/512/pre-budget-2016-final.pdf > 2 accessed 22 February 2017.

[15] Department of Health, *Time to Move On from Congregated Settings: A Strategy for Community Inclusion* (DOH 2011).

[16] ibid.

[17] Health Information and Quality Authority, 'National Standards for Residential Services for Children and Adults with Disabilities' < https://www.hiqa.ie/reports-and-publications/standard/national-standards-residential-services-children-and-adults > accessed 31 March 2017.

[18] Health Service Executive, 'Progressing Disability Services for Children and Young People' < http://www.hse.ie/progressingdisabilityservices/ > accessed 22 February 2017.

[19] Ombudsman for Children's Office, 'Report of the Ombudsman for Children to the UN Committee on the Rights of the Child on the occasion of the examination' < https://www.oco.ie/wp-content/uploads/2014/03/OCO_AltReportUNCRC_2015.pd f> 31.

[20] Health Service Executive 'Disability Services' < http://www.hse.ie/eng/services/list/4/disability/ > accessed 31 March 2017.

[21] Ombudsman for Children's Office, 'Report of the Ombudsman for Children to the UN Committee on the Rights of the Child on the occasion of the examination' < https://www.oco.ie/wp-content/uploads/2014/03/OCO_AltReportUNCRC_2015.pdf > 31.

There are many barriers for children with disabilities in fully accessing their **right to healthcare**. Children continue to experience difficulties in accessing primary and community healthcare services including gaps and delays in service provision for children who require a multi-disciplinary approach; delays in diagnosis; delays and difficulties in accessing equipment; and geographical disparities in the provision of primary care services between HSE areas.[22] Down Syndrome Ireland has highlighted the long delays in accessing Occupational Therapists and Speech and Language Therapists due to a lack of early intervention by the State and school based services.[23] This has resulted in parents having to fund private therapists to help their children communicate and develop their skills to carry out everyday tasks such as feeding, dressing and toileting.[24]

In Budget 2017 the Government announced the allocation of EUR 10 million to provide a medical card to all children who qualify for the Domiciliary Care Allowance, a monthly payment for children under the age of 16 with a severe disability, who require ongoing care and attention, substantially over and above what is usually required by a child of the same age.[25] While draft legislation has been published, it has yet to be enacted and implemented. The high number of applications for Domiciliary Care Allowance that are refused every year and subsequently allowed on appeal is an ongoing issue. In 2016, of the 1,198 applications that were refused, 90 per cent were subsequently revised by a Deciding Officer, allowed on appeal or partially allowed on appeal.[26]

Recent studies suggest that young people in Ireland may have a higher rate of mental health issues than similarly aged young people in other countries.[27] This has not resulted in a correlated level of service provision.[28] Demand for services continues to exceed availability with long waiting lists for Children and Adolescent Mental Health Services. In September 2016, there were 2,080 children waiting for a first appointment with Child and Adolescent Mental Health Services.[29] Of these 1,182 children were waiting for longer than three months and 170 were waiting over one year.[30] In 2016, there was a 19.7% increase in the number of children waiting more than a year for an appointment due to the lack of available primary care based psychological supports and recruitment difficulties in appointing clinical staff.[31]

Currently a young person who needs to access out-of-hours mental health treatment can generally only do so through hospital emergency departments. There are reports of young people

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22 Ombudsman for Children's Office, 'Report of the Ombudsman for Children to the UN Committee on the Rights of the Child on the occasion of the examination' https://www.oco.ie/wp-content/uploads/2014/03/OCO_AltReportUNCRC_2015.pdf 33.

23 Down Syndrome Ireland, 'This World Down Syndrome Day, DSI urges Government to increase vital services for children with Down syndrome' https://downsyndrome.ie/this-world-down-syndrome-day-dsi-urges-government-to-increase-vital-services-for-children-with-down-syndrome/ accessed 31 March 2017.

24 Ibid.

25 Department of Social Protection, 'Domiciliary Care Allowance (DSP)' http://www.welfare.ie/en/Pages/1078_Domiciliary-Care-Allowance.aspx accessed 30 January 2017.

26 Minister for Social Protection, Dr Leo Varadakar TD, Parliamentary Questions, Written Answers, Social Welfare Schemes Data, 24 January 2017 [3228/17].

27 Mary Cannon and others, *The Mental Health of Young People in Ireland: A report of the Psychiatric Epideology Research across the Lifespan (PERL) Group* (RCSI 2013) 7.

28 Health Service Executive, *Fifth Annual Child & Adolescent Mental Health Service Report 2012 – 2013* (HSE2014).

29 Health Service Executive, *Performance Report August/September 2016* (HSE 2016) at 56.

30 Ibid.

31 The increases are mainly restricted to a small number of Community Healthcare Organisations. Communication received by the Children's Rights Alliance from the Health Service Executive, 24 January 2017.

who have attempted suicide after unacceptable waits in busy emergency departments before being assessed.[32] In September 2016, 17.1% of all admissions of children and young people to in-patient mental health services were to adult in-patient units.[33]

On admission to hospital for mental health treatment, children are categorised as either 'voluntary' or 'involuntary' patients. The term 'voluntary' is a misnomer, as by law those under 18 years cannot consent to enter or leave hospital and it is their parent or guardian who has the legal entitlement to provide consent on behalf of their child.[34] 'Voluntary' patients do not have the same level of automatic protections and safeguards as those afforded to 'involuntary' patients.[35]

Methodology

The Irish Legal Innovation Strategy has been developed through consultation with a wide range of stakeholders at national level by the Children's Rights Alliance with input from the Irish Human Rights and Equality Commission on the final draft.

National Human Rights Institution: The Irish Human Rights and Equality Commission delivered the National Training Sessions in November 2016 and provided feedback on a draft of the litigation strategy.

Lawyers: Barristers took part in the Irish training and the National Strategy Day in November 2016. They identified a number of issues during the consultation across the five themes of the training, many of which are captured in the introduction to this strategy. The prominent issue during the training and the consultation was the difficulty in accessing mental health treatment for children and young people. In looking at the contributing issues related to access, they considered the potential legal arguments that could be made.

The participants, many of whom have experience in this area, raised a number of issues arising under this including:

- Waiting lists to access Child and Adolescent Mental Health Services;
- The continued admission of children under 18 to adult in-patient mental health units;
- The lack of Special Care placements for children in the State; and
- The length of time between reviews of the status of children detained under the Mental Health Act 2011.

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[32] A Lust for Life, 'We're Calling on the Government to Make Community Mental Health Care Available 24/7' http://www.alustforlife.com/the-bigger-picture/were-calling-on-the-government-to-make-community-mental-health-care-available-247 accessed 30 January 2017.

[33] Health Service Executive, *Performance Report August/September 2016* (HSE 2016) 56.

[34] A parallel concern is that children on care orders have to be admitted under Section 25 of the Mental Health Act if they wish to voluntarily enter a mental health hospital. This practice has been criticised as stigmatising children in care. See Health Service Executive (2013) National Consent Policy, Dublin: Health Service Executive, Part Two for further detail on children and consent.

[35] E. Ring, 'Children's consent on treatment urged' Irish Examiner [online], 27 June 2012, http://www.irishexaminer.com/ireland/childrens-consent-on-treatment-urged-198795.html; P. Duncan, 'Enhance patient autonomy, advises report' The Irish Times [online], 22 June 2012, http://www.irishtimes.com/newspaper/ireland/2012/0622/1224318456479.html.

Advocacy bodies and service providers: Advocacy bodies working in the area of disability and mental health were consulted by email and telephone on issues relating to mental health, health and education for children with disabilities. They were asked to respond to a number of questions on the progress on commitments made by the current Government in 2016. This provided an added insight as to where the litigation strategy could bolster ongoing work. They highlighted ongoing work in the area of mental health, such as the recently completed review of the Mental Health Act 2011, the Review of *a Vision for Change* and the new Youth Mental Health Taskforce established by the Government.

A number of the stakeholders in this group were concerned at the lack of focus on providing age-appropriate supports for children and young people and in particular the continued admission of children under the age of 18 to adult in-patient mental health units.

Selection of the right

The Irish Legal Innovation Strategy will focus on the right to health, in particular ensuring that every child can access appropriate mental healthcare treatment. The aim of this strategy is to amend the Mental Health Act 2001 ("the 2001 Act") to provide that no child under the age of 18 years should be detained in an adult in-patient unit unless it is in his or her best interests to do so.

The 2001 Act is the primary legislation governing children with mental health problems and their access to mental health services. Even though the 2001 Act was only brought into effect in 2006, it is outdated and is not in line with Ireland's international human rights obligations, particularly as these relate to children.[36] The provisions of the 2001 Act relating to children and young people are spread throughout the Act so the extent to which provisions apply to children is unclear.[37] A review of the Act was recently completed and the *Report by the Department of Health's Expert Group on the review of the Mental Health Act 2001* was published containing a number of important recommendations relating specifically to children including that 'services should be provided in an age-appropriate environment wherever possible'.[38]

The 2001 Act does not require that children and young people be admitted to age-appropriate mental health facilities. As a result, children and young people are routinely placed in adult facilities. In 2016, the UN Committee on the Rights of the Child expressed concern at the ongoing practice of admitting children and young people to adult wards due to inadequate availability of suitable facilities.[39] The Committee has noted that where placement in a psychiatric unit is necessary, adolescents should be separated from adults, where possible.[40] The Mental Health Commission's Code of Practice states that the placement of children in adult wards would be phased out by the end of 2011[41] but this commitment has clearly not been delivered. In September 2016, 17.1% of all admissions of children and young people to in-patient mental

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[36] Mental Health Commission, *Response to the Law Reform Consultation Paper on Children and the Law: Medical Treatment* (2010) 24.

[37] Department of Health and Children, *Report of the Steering Group on the Review of the Mental Health Act 2001,* (DOH 2012) 14.

[38] ibid 73.

[39] CRC, 'Concluding Observations: Ireland' (2016) UN Doc CRC/C/IRL/CO/3-4, para 53.

[40] CRC 'General Comment No. 4 on The Implementation of the Rights of the Child During Adolescence (2016) UN Doc CRC/GC/20 para 29.

[41] Mental Health Commission, *Code of Practice Relating to Admission of Children under the Mental Health Act 2001: Addendum* (MHC 2009).

health services were to adult in-patient units.[42] The continued admission of children to adult units has been criticised repeatedly as being unsatisfactory by the Mental Health Commission.[43]

There are a number of potential legislative and policy opportunities that could be leveraged in obtaining the goal of this strategy including:

- The implementation of the Review of the *Report by the Department of Health's Expert Group on the review of the Mental Health Act 2001* published in 2015;
- The upcoming ratification of the CRPD by Ireland;
- The work of the Youth Mental Health Taskforce;
- Youth mental health is a key priority of the Ombudsman for Children's Office; and
- The upcoming review of *A Vision for Change*, the national policy for mental health service provision.

Overview of the legal remedies

There are many different legal remedies that could have the potential to realise the aim of this strategy in amending the Mental Health Act 2001 to provide that no child under the age of 18 years should be detained involuntarily in an adult in-patient unit unless it is in his or her best interests to do so.

Legal challenge to the detention of a young person in an adult in-patient unit

A legal challenge to the involuntary detention of children in adult in-patient units for mental health treatment could be based on the Judicial Review procedure, or a potential plenary action under Article 40.4.2 of the Irish Constitution and also a challenge based on the violation of the right to freedom from inhuman and degrading treatment and the right to bodily integrity under the European Convention of Human Rights Act 2003.

In order to have legal standing, the action would need to be taken by the parent or guardian of the child. It would be accessible if adequate or pro bono legal resources were to be made available. It is possible that if the case is lost then costs could be awarded against the Plaintiff. The Irish Human Rights and Equality Commission (IHREC) has the statutory power to provide legal assistance to individuals in relation to matters concerning human rights and equality (legal assistance would cover the cost of litigation expenses). Section 40 of the Irish Human Rights and Equality Commission Act (the 2014 Act) sets out the criteria by which IHREC can grant legal assistance. Applications made by individuals are considered on a case by case basis and in line with IHREC's statutory criteria. The ability to grant assistance is also constrained by IHREC's legal budget in any given year. Also, it is worth noting that section 41 of the 2014 Act provides that the IHREC can also take its own named proceedings, in relation to systemic human rights or equality abuses. This is similar to a class action in other jurisdictions.

[42] Health Service Executive, *Performance Report August/September 2016* (HSE 2016) 56.
[43] Mental Health Commission, *Annual Report 2015* (MHC 2016) 8.

1. Complaint to the European Court of Human Rights

A challenge based on the violation of the rights of the child under the European Convention of Human Rights (ECHR) could be taken when domestic remedies have been exhausted. If we argue deprivation of liberty under Article 5 ECHR, we need to be careful in terms of potentially reinforcing the Court's case-law on the interpretation of Article 5(1)(e) – 'persons of unsound mind'.

Also, the action would need to be taken by the parent or guardian of the child. It would be accessible if adequate or pro bono legal resources were made available. Given Ireland's dualist system and the fact that it has not fully incorporated the ECHR into domestic legislation, the enforceability of this decision at a domestic level will have its limitations.

2. Complaint under the Third Optional Protocol to the UN Convention on the Rights of the Child

The Third Optional Protocol to the CRC is a communications procedure/complaints mechanism. It establishes a quasi-judicial mechanism that allows children and their representatives to submit a complaint to the UN CRC Committee regarding specific violations of their rights under the CRC and its first two optional protocols, if ratified.

Ireland signed the Third Optional Protocol (OP3) to the UN Convention on the Rights of the Child in September 2014. A complaint can only be made after domestic remedies have been exhausted. This means that a complainant must show that they have engaged with the existing complaints mechanisms available in his or her own country. In Ireland, there are many existing legal and quasi-legal remedies open to children and families when their rights are violated, such as taking a case through the courts, or making a complaint to the Ombudsman for Children's office.

Decisions by the Committee are non-binding on States. However, by ratifying the OP3, States commit themselves to follow the decisions and provide redress to victims. The OP3 provides for the facilitation of friendly settlements, if parties to the communication find an agreeable solution between themselves.

Ireland has also opted into the Inquiry Procedure which provides for any person or organisation the ability to submit information to the Committee alleging grave or systematic children's rights violations under the CRC by a State. If the Committee receives reliable information indicating that grave or systematic children's rights violations continue to occur, it can decide to conduct an inquiry. The inquiry procedure could be very useful in seeking to amend the Mental Health Act 2001 to provide that no child under the age of 18 years should be detained involuntarily in an adult in-patient unit unless it is in his or her best interests to do so. As this is a systematic violation of children's rights, it would be possible to work with the stakeholders consulted for this strategy to develop a compelling file of information for the purposes of requesting an inquiry. As there are a number of potential legislative and policy opportunities that could be leveraged in obtaining the goal of this strategy, an investigation by the Committee on the Rights of the Child could help strengthen the argument to change the legislation.

Case Selection and Litigation plan

1. Suggested client intake processes

In order to ensure that the best potential client is identified for the legal action we will develop and consolidate relationships with second tier advice givers and people who work with children

that are detained involuntarily in adult in-patient units. We would make them aware of the profile of client we are looking for so they could refer them to us. We will screen all referrals to see if they are a suitable fit for the litigation and if they are willing to take on the risks associated with litigation as set out above.

The client profile we would be looking to satisfy is as follows:

- A young person who is involuntarily detained under the Mental Health Act 2001;
- The young person is being detained in an adult in-patient unit; and
- The parent/guardian is willing to take on the risks of litigation such as costs potentially being awarded against them.

2. Litigation Route to Follow

On identifying a potential client, and confirming that the legal and factual merits of the individual case are strong, the next step will be to explore what remedies are practically available. We do not have an in-house legal team, so we would have to explore, either through applying to IHREC (pursuant to section 40, or potentially making a request under 41 of the 2014 Act), or entering into a partnership with a community law centre, such as for example the Free Legal Advice Centres (FLAC), or seeking whether a private law firm would provide support, through the public interest law centre. Litigation through the domestic courts is likely to yield the strongest results in the context of changing domestic law. It is also the first step to take before engaging the possible regional and international complaints mechanisms.

In parallel, it may be open to pursue the Inquiry Procedure, through the CRC. We would not have to engage a legal team to make such a communication (arguably we would have the skills in-house to complete same). While there is a requirement to exhaust all domestic remedies for the Inquiry Procedure, it does not apply where the application of remedies is unreasonably prolonged or unlikely to bring effective relief.

Pursuing parallel remedies may glean stronger results. For example, if we were to receive a strong finding at international level this would strengthen domestic litigation.

Risk Management

It is difficult to clearly set out a risk management plan without a client, access to the particular facts and engagement with the relevant legal team. However, a plan would identify the following as headline risks:

Identified Risk	Risk mitigation
Risk 1: Client specific risks	
Legal standing of guardian	Necessary to confirm that guardian has legal standing, this may arise in certain cases where parents are separated, or where an advocate has been appointed.
Issues surrounding capacity	Client may turn 18 during the course of proceedings. If capacity is a concern, or potentially challenged, a medical assessment will be required.

Communication barriers	Communication aides may need to be identified. An advocate or other support may need to be identified where necessary. Legal team will need to have appropriate training and expertise in communicating with the client.
Risk 2: Managing relationship/ expectation with client	
Clear understanding of scope of assistance granted	Terms and conditions of offer to clearly set out scope, and limitation of assistance. We will need to clearly specify situations where assistance should be withdrawn. Assistance should be staged, to allow for legal team to consider merits of pursuing at each stage. We will need to clearly set out level and extent of expense that grant of assistance will cover and what will not be covered.
Cost implications clearly communicated	The terms and conditions should address cost implications where the client loses proceedings and what this means.
Impact of litigation on client	Legal proceedings are lengthy and emotionally stressful. Clients might seek to withdraw from litigation. The appropriate supports should be in place for client such as access to peer support and professional support if needed.
Risk 3: Media	
Risk of misrepresentation, and need to ensure a clear and consistent media message is provided.	There may be a need to restrict the client's contact with the press, or other media, without prior consultation or agreement. A willingness to work with media will be an important aspect in terms of pursuing the issue strategically. This might be built into the terms and condition of offer. However, it may not be appropriate in every case, depending on the specifics of the case, and the wishes of the client. Such a clause should be considered when the client has been identified.
Risk 4: Costs and resources	
Depending on the legal route (judicial review or plenary) it may require expert evidence, and extensive legal research.	The identified legal team should set out projected costs and a resource plan to ensure that they can deliver on the litigation plan. This should be reviewed periodically.
Risk 5: Length of legal proceedings	
Legal proceedings are lengthy and may continue for a number of years. Factors such as the likelihood of appeal, etc should be considered at this early stage. This may also give rise to client fatigue.	Need to seek to address this at outset so that the client understands this will be part of process (i.e. not a quick fix). May be necessary to provide other supports for client such as peer support and professional support if needed.
Risk 6: Case outcome	

The Court could make a finding affirming bad law, or set unhelpful precedent. Alternatively, the decision although potentially positive for the individual client could create a situation which impacts negatively on other children and adults with disabilities, who require similar services.	All the possible consequences need to be considered and weighed against the positive outcomes in advance of pursuing any such litigation. Even if a positive outcome is achieved, the strategic impact may be limited if pursued in isolation. The strategy also identifies and pursues other methods, via media, research, policy documents, and political pressure. This will be resource intensive, and will need to be planned at the outset. However, it is essential in terms of ensuring optimum outcome.

Follow up activities

There are many upcoming opportunities that may supplement litigation to achieve the aim of this strategy.

The Review of the *Report by the Department of Health's Expert Group on the review of the Mental Health Act 2001* was published in 2015. The general scheme of a Bill to amend the Mental Health Act 2001 to reflect the recommendations of the review in revised legislation is currently being drafted and is expected to be finalised by mid-2017.[44] This provides an opportunity to engage in advocacy with legislators to include in the Bill a provision that no child under the age of 18 years should be admitted to an adult in-patient unit unless it is in his or her best interests to do so.

Ireland is expected to ratify the UN Convention on the Rights of Persons with Disabilities in 2017. Should this happen, it will allow for the Committee on the Rights of Persons with Disabilities to engage in reviews of Ireland's compliance with the Convention. This would be an opportunity to put pressure on the Irish Government to amend the Mental Health Act 2001 to ensure that no child under the age of 18 years should be admitted to an adult in-patient unit unless it is in his or her best interests to do so.

The review of *A Vision for Change* (the national policy for mental health) has commenced with an expert appointed to assess national and international best practice in the development and delivery of mental health services.[45] This review will form the basis for the development of a new policy for mental health.[46] This provides an opportunity to engage in advocacy with legislators to include in the Bill a provision that no child under the age of 18 years should be admitted to an adult in-patient unit unless it is in his or her best interests to do so.

Resources

Human Resources Necessary

[44] Minister of State for Mental Health and Older People, Helen McEntee TD, Written answers, Mental Health Policy, Tuesday 17 January 2017 [41570/16].

[45] Ibid.

[46] Minister of State for Mental Health and Older People, Helen McEntee TD, Dail Debates, Mental Health Services Funding: Motion [Private Members], 15 November 2016.

a. Second Tier advice givers and people working with children detained involuntarily in inpatient units in identifying and referring suitable clients.
b. Internal Resources in co-ordinating the CRC complaint and co-ordinating the legal team and second tier advice givers.
c. Legal Team developed either through making a successful application to the IHREC or collaborating with a community law centre.
d. International NGO may be needed to provide support in pursuing a complaint to the Committee on the Rights of the Child.

Financial Resources Necessary

a. Court fees: The cases can be litigated by pro bono lawyers through a successful application to the IHREC or in conjunction with a community law centre.